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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

DARTMOUTH-HITCHCOCK CLINIC, ET AL	*	11-CV-358-SM
	*	January 10, 2012
v.	*	9:40 a.m.
NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES, COMMISSIONER	*	

TRANSCRIPT OF EVIDENTIARY HEARING
MORNING SESSION
BEFORE THE HONORABLE STEVEN J. MCAULIFFE

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I N D E X

P R O C E E D I N G S

THE CLERK: Court is in session and has for consideration a hearing on a motion for preliminary injunction in Dartmouth-Hitchcock Clinic, et al, versus New Hampshire Department of Health and Human Services, civil case number 11-CV-358-SM.

THE COURT: All right. Good morning. It must be an interesting case. Plaintiffs.

MR. O'CONNELL: Good morning, your Honor.

THE COURT: Are you ready to go?

MR. O'CONNELL: We are.

THE COURT: All right.

MR. O'CONNELL: The plaintiffs call Henry Lipman to the stand.

THE COURT: Mr. O'Connell, I haven't looked at your request for findings of facts. I was just told it was 84 pages or something.

MR. O'CONNELL: Yes, it is, your Honor.

THE COURT: I'll take a look at it. What's your anticipated time?

MR. O'CONNELL: For this witness or for the whole case?

THE COURT: No. For your witnesses.

MR. O'CONNELL: Our plan was to be done by

midday tomorrow, if possible.

THE COURT: Try the end of the day today.

MR. O'CONNELL: Really?

THE COURT: Yeah. We're not going to be too repetitive, right?

MR. O'CONNELL: We're going to do everything we can to move this along.

THE COURT: I'll help you move along.

MR. O'CONNELL: I have no doubt.

There are also a number of state witnesses who were not alerted to be here today that we would call tomorrow, and Dr. Butterly from Dartmouth-Hitchcock we've asked to be here tomorrow. He didn't cancel his rounds today. We scheduled him for first thing tomorrow. So we can take him out of order.

THE COURT: All right.

HENRY LIPMAN

having been duly sworn, testified as follows:

THE CLERK: Would you please state your name for the record and spell your last name please?

THE WITNESS: It's Henry. Middle initial D, as in David. L-I-P-M-A-N, Lipman.

MR. O'CONNELL: Please be seated, Mr.

Lipman.

DIRECT EXAMINATION

BY MR. O'CONNELL:

Q. Where do you live, sir?

A. I live in Laconia, New Hampshire.

Q. How long have you lived in Laconia?

A. 23 years.

Q. Are you married?

A. Yes, I am.

Q. Do you have children?

A. Two children.

Q. Are you currently employed?

A. I am.

Q. Where are you employed, sir?

A. At LRG Healthcare.

Q. What is LRG Healthcare, please?

A. LRG Healthcare is a two-hospital group, Lakes Region General Hospital in Laconia and Franklin Regional Hospital in Franklin, New Hampshire.

Q. Will you tell us a little bit more about Lakes Region Hospital? How many beds does it have?

A. Lakes Region is licensed for 137 beds.

Q. And Franklin Hospital?

A. It's a 25-bed critical access hospital.
Q. What is your position?
A. I'm the Senior Vice President for Financial Strategies and External Relations.
Q. Would you tell the Court what your responsibilities include with that role?
A. I oversee the finances of the group of hospitals and our provider practices, as well as external relations, public policy.
Q. Are you familiar with the financial operations of LRG Healthcare?
A. Absolutely.
Q. Are you responsible for those issues with regard to that corporation?
A. Yes, I am.
Q. Would you summarize your education, please?
A. I have a Bachelor of Science in health management and policy from the University of New Hampshire. I graduated 1981. An MBA from Boston University with a healthcare management concentration. I graduated in 1985.
Q. How long have you been employed in healthcare administration?
A. A little over 30 years.

Q. I would like to talk with you in some detail now about the LRG health system. Would you please tell the Court what its mission is?

A. Our mission is to provide quality and compassionate healthcare services to strengthen our community.

Q. How long has that been the mission of the hospitals?

A. LRG Healthcare was formed in July of 2002. Recently we did make a change in our mission. It used to read: To provide accessible quality and compassionate care. We dropped the word accessible.

Q. Why did you make that change?

A. Because of the financial strings that we're under as a result of the state change in the commitment to the Medicaid program, as well as other financial challenges that have been generated by the economy at large.

Q. So what are the implications of the change of your mission as you've just described it with regard to Medicaid patients?

A. That the access that we have historically provided for the life of the organization is at risk, and we've had to take actions to limit it to

some extent.

Q. Would you summarize for the Court the actions that you've taken at the Lakes Region General Hospital to deal with the financial circumstances of the state's recent decisions?

A. I kind of describe it as sort of we have kind of four buckets to work with.

The first bucket is the bucket of profitability. And to a large extent operating in the red there's nothing more to have there.

The second bucket we can work on is sort of productivity, which is trying to increase the efficiencies and the economies of the organization. We've improved that by tens of millions of dollars. We continue to work on that.

The third area that we could work on is cost shifting. But with the way health insurance premiums are in New Hampshire and the position of insurers, we can no longer do much of anything there.

And the last one which we've heretofore never had to address is access.

Q. Has Lakes Region General ever had to consider the payer status of a patient at the time it was going to administer services?

A. No.
Q. Has that changed?
A. Yes.
Q. In what way has it changed?
A. We have started to do a few things. The first which we implemented was discharging from our primary care practices Medicaid patients. We have modified our financial and charitable systems programs, and we are also working on implementing the concept of limiting elective -- what we call avoidable elective care.
Q. And why are you implementing those changes now?
A. Well, the overwhelming impact of the state budget change in terms of the pulling out of for us a year over year change of 10 million, 130 million affecting the ten hospitals, and the compounding of that from the preexisting rate cuts, which through the biennium will be somewhere around $11.6 million.
Q. Lakes Region is a plaintiff in this lawsuit?
A. We certainly are.
Q. What was the reason that Lakes Region brought suit now with the other plaintiffs?

A. We're just in such a compromised position in terms of meeting our community needs that we see no choice.

Q. What relief do you seek from the Court by this action?

A. We're looking for an injunction to have the state fulfill its responsibility under the Medicaid Act, to assess what the impacts are on access, as well as to make sure that the impact on patients themselves, that they have a say in what's gone on.

Q. Let's talk a little bit further about your health system and focus on the hospitals. Lakes Region, does it have any certain designations that it operates with?

A. Yes, we do.

Q. Would you summarize those for the Court, please?

A. We have a sole community hospital status.

Q. What does that mean, sole community hospital status?

A. Medicare looks at certain hospitals because of their geographic location and the dependency of the population in that area on that particular institution. That they make certain

adjustments in the payment system to make sure that access isn't compromised, and we're one of two sole community hospitals in New Hampshire.

Q. Does the case before the Court involve Medicare at all?

A. Not directly, but the Medicaid program is overseen by CMS, Centers for Medicaid and Medicare Services.

Q. When we talk about the financial issues, they pertain to Medicaid specific decisions; is that right?

A. Correct.

Q. In addition to the designation you just described and the purpose for it, what other designations does Lakes Region have?

A. It's a rural referral center under Medicare as well.

Q. What does that mean?

A. Which, again, is part geography and part reflects a certain size and intensity of service that we provide the population. That the population somewhat depends on, if you will, the secondary services that we would provide. We're one of three in New Hampshire.

Q. As a practical matter, what is the

significance of those designations with regard to the patients that you serve?

A. I think they're reflective that there's a high dependency in our service area on our institution for hospital services and that the socio-demographics of the area are more adverse than you might otherwise expect.

Q. In what way is Franklin Hospital different than Lakes?

A. Franklin Hospital is a critical access hospital.

Q. And what does that mean?

A. A critical access hospital is, again, a Medicare designation. The Medicare designation is provided to address a couple of issues. One is, again, geographic. A second aspect of this is socio-economic and healthcare needs of a population. And the third is fundamentally dealing with financial actuarial risk. Because of the size of these hospitals, that their ability to absorb certain financial risks under the payment system that the larger hospitals take is more limited because they don't have the volume to offset the actuarial variability.

Q. Which of the institutions, Lakes Region or

Franklin, has been more directly impacted by the Medicaid changes?

A. Lakes Region.

Q. Systemwide how many employees does LRG Healthcare have?

A. We have approximately 1,200 FTEs, which is about 1,600 persons.

Q. FTEs?

A. Full-time employees.

Q. And the number of people who actually show up from time to time is what number?

A. Approximately 1,600.

Q. Can you describe for the Court what your primary service area is for Lakes Region?

A. Generally, it's the central part of the state, which is described generally as the Lakes Region, and the Twin Rivers area. More specifically, the service area is generally the area where we serve a community. The majority or plurality of volume comes from there to our hospital.

There are other definitions that are used. It's not a single standard.

Q. Does every hospital, at least the plaintiffs in this case, have a primary service

area?

A. Absolutely.

Q. Are you familiar with the Medicaid population as it exists in your primary service area?

A. I am.

Q. I would like you to look, sir, at what's been marked as a full exhibit, Plaintiff's Exhibit 50. Sir, do you recognize that document?

A. I do.

Q. What is it?

A. It's the New Hampshire Medicaid annual report for state fiscal year 2010.

Q. Is that a report you're familiar with?

A. This report I am.

Q. How often is it produced?

A. Each fiscal year there's a report, to my understanding.

Q. Would you turn your attention to page 11? Do you see the graphic known as figure 10?

A. Yes, I do.

Q. There's a reproduction of that on the board in front of you? I'm sorry, would you answer audibly?

A. Yes. I'm sorry.

Q. Thank you. Would you identify on that map, sir, where your service area is located?

A. It's the service area of Laconia and Franklin, which is sort of an orange color to the center of the state -- a darker orange.

Q. And this chart contained in the state's report says it's the Medicaid enrollees as a percent of total population; is that correct?

A. It does. Yes.

Q. What is the Medicaid percent of population for the Laconia service area referenced on this chart?

A. 13 percent.

Q. And what is the total number as counted by the state?

A. 6,372.

Q. For Franklin what is the percent of population that is Medicaid enrolled?

A. 16 percent.

Q. And what is the number there?

A. 2,773.

Q. Is it a fair summary, sir, that those two populations added together constitute the Medicaid population you try to serve in your primary service area?

A. Yes, it does.
Q. Do you serve Medicaid patients from outside your primary service area?
A. We do.
Q. How does that occur?
A. For certain services that other hospitals -- particularly in our area critical access hospitals that don't provide something like vascular surgery might come to our hospital because there isn't a source in their local community.
Q. So it's not an exclusive primary service area, and you will treat Medicaid patients that come from other parts of the state? Is that true?
A. Right. That is true.
Q. Just to summarize the data from this chart for some of the other plaintiffs in this case, do you see the Lebanon area?
A. I do.
Q. Is that where Dartmouth-Hitchcock has its primary service area?
A. Yes.
Q. What percentage does it have of population?
A. 7 percent.

MR. O'CONNELL: I have another copy that the Court might find more useful than the chart. The defendants already have it. I'll give the witness a copy of something that might be a little more readable.

Q. So, I'm sorry, I was asking you about Dartmouth-Hitchcock. You said 7 percent?

A. Yes.

Q. And the actual number for that area?

A. 4,527.

Q. Does Dartmouth-Hitchcock have a role beyond its primary service area that is recognized by the other hospitals like Lakes Region?

A. Yes, they do.

Q. What is their role?

A. Their role is really as the only statewide tertiary center in the state. They provide certain services that aren't available elsewhere that otherwise you might have to go to another state to find.

Q. When you say tertiary care center, can you describe what that means?

A. Actually, tertiary refers to a complexity and intensity of services. Like an example that might be common would be open heart surgery, which

isn't necessarily exclusively at Dartmouth, but there may be certain research. And there's another term called cortenary services, which is even higher, the types of things you expect to find in a teaching institution where they do research.

Q. Are you familiar with the term safety net hospital?

A. I am.

Q. What does that mean?

A. It means that it's a hospital that has a role of providing access where there may be no other source to. And for us there are times when Dartmouth serves that purpose for our community.

Q. Would you look at the area on figure 10 of Exhibit 50 for Keene? Do you see that reference?

A. I do.

Q. Is one of the plaintiff hospitals located in Keene?

A. Yes.

Q. Which one is that?

A. That's Cheshire Medical Center.

Q. What is the percent of population of Medicaid enrollment for Keene?

A. 11 percent.

MS. SMITH: Your Honor, this is outside his personal knowledge. He can testify to what the page says, but I don't know that he has personal knowledge.

THE COURT: I agree.

MR. O'CONNELL: I'm just trying to set it up to move it --

THE COURT: I know, but you can cover in one question probably ten minutes all of this.

Does that chart fairly represent the percentage of Medicaid patients by geographic distribution as depicted?

THE WITNESS: Yes.

THE COURT: Super.

MR. O'CONNELL: Thank you.

Q. Sir, have you tried to for purposes of this case calculate the portion of revenue that Lakes Region -- LRG Healthcare, the system, derives from Medicaid services?

A. Yes.

Q. And where did you perform that calculation or where is that calculation located? Is that in an affidavit that you prepared?

A. It is in the affidavit that we submitted.

Q. I turn your attention and the Court's

attention to Exhibit 76.

THE COURT: If it's easier for you, Mr. O'Connell, I can see it.

MR. O'CONNELL: You can? Thank you, your Honor. We weren't confident we could get the technology right so we have paper, too. Thank you.

Q. Mr. Lipman, is this a copy of a declaration that you prepared and submitted in connection with this case?

A. Yes.

Q. Does it contain true and accurate calculations that you prepared concerning this case?

A. It does. With the supplemental affidavit submitted, 2 and 3.

Q. You have submitted two other declarations in this case?

A. Yes.

Q. We'll talk about that. Together those three declarations you believe are accurate?

A. Yes.

Q. Okay. Would you turn your attention, sir, to the calculations contained in table 1 on page 5? Did you perform these calculations, or were

they done under your instruction?

A. I supervised.

Q. Okay. Would you summarize for the Court the amount of revenue that is generated on an annual basis through Medicaid services at Lakes Region as of last year?

A. 10.31 percent.

Q. And how has that changed from the prior four years represented on the chart?

A. It's increased from 8.15 percent in 2006 to 10.31 percent in 2010.

Q. You can put that aside for the moment. Can you summarize for the Court the nature of the Medicaid program as it relates between the state and the federal government, just generally?

A. It's a partnership between the state and the federal government which has funding coming from both the state and the federal government. It has a categorical approach as serving certain distinct populations, some based on finances in terms of their poverty level, and some based on certain categories, like women and children, the blind, disabled.

Q. The state provides some of the funding for the Medicaid program; is that right?

A. They do.
Q. And what has traditionally been the source of that funding?
A. A large portion has been the Medicaid enhancement tax.
Q. And who is responsible for paying the Medicaid enhancement tax?
A. Hospitals.
Q. Does the federal government provide any funding for the state's -- New Hampshire's Medicaid program?
A. It does.
Q. Generally speaking, what is the nature of that funding?
A. It's a matching, generally.
Q. When you say matching, would you describe what that means?
A. The money that would be put up on behalf of the state, whether it came from Medicaid enhancement tax or what have you, would be matched generally on a 50/50 basis between the state and federal government in our instance.
Q. Who administers the Medicaid program in New Hampshire?
A. The Department of Health and Human

Services.

Q. Does the federal government have any role in administering the program?

A. Yes. They supervise the operation of the program, and it generally is done through what's called state plan amendments or SPAs.

Q. What is the division of the federal government that has responsibility for overseeing the Medicaid program in New Hampshire?

A. Centers of Medicaid --

MS. SMITH: Objection. It calls for a legal conclusion.

MR. O'CONNELL: I'll withdraw it.

THE COURT: Oh, heavens. Everybody understands it anyway.

MR. O'CONNELL: Okay.

Q. We use the term CMS. That's Center for Medicaid Services?

A. That's right.

Q. All right. Are you familiar, sir, with the requirements of how the state is to set reimbursement rates for Medicaid?

A. In terms of -- yes. I guess in terms of the process that is supposed to take place there's a standard which relates to economy, efficiency,

quality and access.

Q. I would like you, sir, to turn your attention to Exhibit 49, which I will put in front of you in a second. I just need to confirm whether this is a full exhibit because it's not marked as such. Yes, it is. Would you identify that document, sir?

A. It's titled The New Hampshire Department of Health and Human Services Office of Medicaid Business Policy, Orientation to Medicaid and CHIP Program, State Fiscal Year 2012-2013 Budget Presented to Sante Fe's Medicaid Overview April 7, 2011.

Q. Would you turn your attention to page 13, please? Do you have that in front of you, sir?

A. I do.

Q. Have you seen this document before today?

A. I have.

Q. Do you see that there's a reference to 42 CFR 447.252(b)?

A. Yes.

Q. Does this placard accurately represent what your understanding is, sir, for what is to be included in a state plan --

A. It does.

Q. -- for Medicaid?
A. It does.
MS. SMITH: Objection. It calls for a legal conclusion and it's leading.
THE COURT: Overruled.
Q. The first point, sir, says: Must allow all parties to understand the rate setting process, the items and services that are paid for these rates; is that correct?
A. Yes.
Q. That's what it says. Is that your understanding of how the state has compiled a state plan?
A. No.
Q. In what way has the state deviated from that based on your personal knowledge?
A. The methodologies both pre and post regulations have not been publicly provided.
Q. The third bullet, sir, says: Section 1902(a)(30) requires payments for services to be consistent with efficiency, economy and quality of care. Do you see that reference?
A. I do.
Q. With regard to the implementation of the rates for this state's fiscal year, are you aware

of any effort by the state to maintain efficiency, economy and quality of care at Lakes Region?

A. No.

Q. There's a reference in the fourth bullet to the upper payment limit, the UPL. Do you see that reference?

A. I do.

Q. What is that, sir?

A. Upper payment limit is a method of enhancing the Medicaid rates that are paid. It allows the state to increase the Medicaid rate up to as high as Medicare.

Q. So can you generally describe the way that that payment is determined?

A. They would look at -- each individual institution would have its own, if you will, limits based on what it received in payments and how that would be under the Medicare amount if it was paid under Medicare.

Q. The next bullet says that: Section 1902(a)(2) provides that the lack of adequate funds from state and local resources will not result in lowering the amount, duration, scope or quality of care and services available. Do you see that reference?

A. I do.
Q. Was there any process which you were aware this year which looked at whether or not the funds provided from state local resources would result -- or not result in the lowering in the amount of duration, scope or quality of care?
A. No.
Q. Would you turn your attention to page 14 of this exhibit, please? You referred to state plan amendments a moment ago, sir. What's your understanding of what a state plan amendment is?
A. It's a communication from the state to the Centers of Medicare and Medicaid Services explaining what the change or the proposal would be to provide payment for Medicaid services.
Q. The first reference underneath that says public process requirements. Do you see that?
A. I do.
Q. Sir, were you aware of any notice to Lakes Region General Hospital before the implementation of this year's budget which contained Medicaid reductions?
A. Not -- no. Not related to the requirements as I understand them for Medicaid.
Q. What do you understand the requirements to

be, sir?

A. That there be an opportunity -- as similarly described earlier, that there be an opportunity for there to be a notice of what the change is going to be. That the methodology that is going to be changed or adopted, that we see what that be. That there would be a chance for comment. That that methodology and whatever comments would be, that you would see what the final would be. There would be an assessment of what the impact would be to beneficiaries in terms of access both pre and post. That there would be an assessment against the ability of an economically -- reasonably economically efficient provider to be able to provide the services for the rates that are being published.

Q. So let me ask: Were there any public notices of which you were aware before the enactment of this budget, July 1st of 2011, that provided you notice of what was going to change with regard to your Medicaid reimbursements?

A. No.

Q. Were you given any time to provide written input to the decision makers at the Department of Health and Human Services about the intended

changes?

A. No.

Q. Do you see the next bullet there that says assurance requirements regarding access to care?

A. I'm sorry?

Q. The second item underneath the state plan amendments.

A. Yes.

Q. Do you see the reference to assurance requirements regarding access to care?

A. Yes.

Q. Were you aware of any inquiry by the Department of Health and Human Services prior to the enactment of this budget that looked at the implications of access to care to Medicaid patients by this budget?

A. No.

Q. Do you see the next reference, sir, about CMS?

A. Yes.

Q. And the state's document says CMS: What impact does proposed SPA have on the ability and access to the service? Do you see that reference?

A. I do.

Q. Do you see the bullet underneath that:

Will reduction in rates allow the state to comply with 1902(a)(30)? Do you see that?

A. Yes.

Q. Are you aware of anything provided at Lakes Region, any communication from the Department of Health and Human Services to CMS that did an assessment about the availability and access to service of Medicaid patients that would result by the reductions of this budget?

A. No.

Q. The next bullet talks in terms of: How did the state determine that the Medicaid provider payments are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area? Do you see that reference?

A. I do.

Q. Are you aware, sir, of any study done by the Department of Health and Human Services to determine whether the new budget implemented this year would enlist enough providers to assure access to care?

A. No.

Q. In fact, with regard to access to care,

what has Lakes done because of the financial implications at its hospital?

A. Thus far, we have sent a letter to 3,000 patients who were in our primary care practices, adults, notifying them following the AMA guidelines for discharging separation from a practice, and we excluded from that pediatric, children, and pregnant women, and have effected that policy change of not accepting existing patients or new patients into those practices.

We have adopted a policy to reduce our charitable assistance to the community, and we have started to implement a process to restrict what we are terming avoidable elective care to the people in our community.

Q. And the point of those actions are to do what, sir?

A. It's to try to reflect the reality of the economic conditions that have been pushed on us by the adoption of this budget. That we have to make adjustments so that we continue to make sure that the facility is -- the facilities and services are available to the community to the best extent possible. That what we've been used to providing to the community for access is no longer

sustainable based on the economics.

Q. The last bullet of this Exhibit 49, sir -- I'm sorry, the second to the last: How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? Were there concerns? How did the state respond? Do you see that reference?

A. Yes.

Q. Was Lakes Region engaged in any discussions concerning access issues or the implications on care because of the state's budget?

A. No.

Q. The last bullet references: How does the state intend to monitor impact of new rates and implement remedy should rates be insufficient to guarantee required access levels? Do you see that reference?

A. Yes.

Q. Are you aware of any actions by the Department of Health and Human Services to monitor the impacts to access as a result of the new budget that has been implemented?

A. No.

Q. I would like to turn your attention to

Exhibit for ID 63. Sir, do you recognize this document?

A. I do.

Q. What does it represent?

A. It represents the transaction for state fiscal year 2011 with respect to the MET, the UPL and the DSH, and the impact related to uncompensated care.

Q. Do you know the source of this data?

A. It's the state's, Department of Health and Human Services, charts that they published associated with the transaction.

Q. To your knowledge does this accurately compile the state's data in just this format for presentation here?

A. It does.

Q. Would you please, sir, tell us what the first line represents -- the first column, excuse me, MET.

A. That's the Medicaid enhancement tax.

Q. And that's for Lakes Region in fiscal year 2011 with what amount, sir?

A. $5,756,123.

Q. The next column references what, sir?

A. The inpatient UPL payment.

Q. Again, UPL was -- you define UPL. What is inpatient UPL?

A. In it's simplest form, it would be what the state was able to pay in additional dollars above the preliminary Medicaid rates, but not more than Medicare.

Q. And that second column represents for inpatient Medicaid services?

A. Correct.

Q. Would you look at the third column, sir?

A. Yes.

Q. What does that number with regard to outpatient UPL payments represent?

A. Similar to the inpatient setting, it represents on the outpatient setting those dollars that could be paid that were less than Medicare, or not to exceed Medicare.

Q. And in 2011 that number for outpatient UPL was what?

A. 1,478,477.

Q. The next column is under something called DSH, D-S-H. What is DSH?

A. It stands for disproportionate share.

Q. And what does a DSH payment represent, generally?

A. It generally represents a supplemental payment to reflect the hospital's share of low income Medicaid and uninsured patients that a hospital might serve.

Q. And what number is that for Lakes last year?

A. 2,965,187.

Q. So if you add those columns together under inpatient UPL, outpatient UPL and DSH for Lakes, the payment last year was what?

A. 7,064,268.

Q. And if you were to compare that against the MET, were you a net payer or receiver of funds say for the year 2011?

A. A net receiver under the net payment column of 1,308,145.

Q. So that was money that Lakes got in the last budget?

A. Correct.

Q. What is the next column, sir? It says "uncomp care".

A. It's a total calculation of uncompensated care which reflects the cost -- on a cost basis, meaning that it's brought down and evaluated at the true cost to the facility for treating

Medicaid patients as well as the uninsured?

Q. And that number for state fiscal year 2011 at Lakes was what number?

A. 11,113,652.

Q. Does the state generally track your uncompensated care?

A. In terms of the recent transactions, yes.

Q. So if you were to take the net payments for UPL and DSH against your uncompensated care, what was the impact in state fiscal year 2011 for Lakes Region?

A. Lakes Region was left to absorb $9,805,507 of uncompensated care.

MR. O'CONNELL: Your Honor, I would offer this as a compilation, the source data, as a full exhibit.

THE COURT: Any objection?

MS. SMITH: I would object to it.

THE COURT: ID may be stricken on Exhibit 63.

(Plaintiff's Exhibit No. 63 Admitted)

Q. Can you just summarize for the Court -- this summarizes the total impact of the ten plaintiffs in this lawsuit in that last column. Just for the record, would you read what that

number is?

A. You're referring to the total UCC payments or total impact?

Q. Total impact.

A. Total impact is 196,467,712.

Q. And just to be clear, the math for the total impact is done how? Which columns are taken into consideration for total impact?

A. The MET, which is column 1; the total UCC payments, which is column 4; and then the uncompensated care column, which is the second to the last column, net to the total impact of 196.

Q. It says total UCC payments. In the parlance of what we're talking about, what does UCC stand for?

A. It's uncompensated care, which is really the summary of the three columns preceding it. The 130 million was the number that I was referring to earlier, which is why we're here bringing the litigation is because that number doesn't get paid to the ten plaintiffs in 2012.

Q. This is just the number for the ten plaintiffs, not all hospitals in the state, correct?

A. Correct.

Q. Would you turn your attention to Exhibit 64, which I will put in front of you? Do you recognize Exhibit 64 marked for ID?

A. I do.

Q. Would you describe what that document is, sir?

A. It describes the New Hampshire state fiscal year 2012 transaction. It's the same setup as the previous chart we looked at. It describes -- for the ten hospitals it shows for UPL, whether it be inpatient, outpatient or DSH, zeros, which means there's a $130 million difference between 11 and 12.

Q. Do you know the source of the data for Exhibit 64?

A. It's data published by the state supplied in support of a DSH transaction that has partially taken place in 2012.

Q. Is this a summary of that data issued by the state?

A. It is for the ten hospitals.

Q. Is this exhibit calculated in the same fashion as Exhibit 63?

A. It is.

Q. None of the ten hospitals in state fiscal

year 2012 received any inpatient UPL payments; is that what it represents?

A. Yes.

Q. Is it the same for outpatient UPL, sir?

A. Yes.

Q. And for the DSH payment, also true?

A. Yes.

Q. The total UCC payments for the ten hospitals was zero in state fiscal year 2012?

A. Yes.

Q. The state still collected the Medicaid enhancement tax for the ten hospitals in state fiscal year 2012?

A. The hospitals have paid, yes.

Q. And that left column represents what?

A. The projected MET payments as calculated by the Department of Health and Human Services based on a form that was provided to the providers to complete and submit to the Department of Health and Human Services.

Q. And the total of MET projected by the state for the ten hospitals is what number on this chart?

A. 124,522,691.

Q. And the net payment column is just a

carry-over of the projected MET; is that right?

A. Correct.

Q. The next column represents what information, sir?

A. It represents the uncompensated care calculation for Medicaid loss and uninsured losses as calculated by the department using the information supplied by hospitals on their Department of Health and Human Services input form.

Q. The same uncompensated care that you described, except in a different year?

A. Yes. Correct.

Q. And so the total impact for state fiscal year using the state's source data is what for fiscal year 2012?

A. The ten plaintiff hospitals are to absorb $302,015,867 in uncompensated care.

Q. So if state fiscal year 2011 has a baseline of 196 million, what is the net impact to the ten hospitals in state fiscal year 12?

A. They will have to absorb another 105,548,155.

Q. Now, with regard to those changes, the reduction of inpatient UPL at Lakes is a zero.

Was there any public notice of that to Lakes Region?

A. No.

Q. Was Lakes Region provided any opportunity to provide written input to the Commissioner of Health and Human Services about the impact of that decision?

A. Not before it was implemented.

Q. So after the fact the state has asked for that information; is that true?

A. Correct.

Q. How about with outpatient UPL, the same, any opportunity before the budget was implemented to provide written comments to the commissioner about the impacts?

A. It's the same everywhere.

Q. No opportunity?

A. No opportunity, no.

Q. And with regard to DSH payments, were you provided at Lakes an opportunity to provide input to the commissioner before the implementation of the budget?

A. No, we weren't.

Q. Were you asked by the commissioner or any of his staff to assess the impact of not receiving

UPL or DSH payments in state fiscal year 2012?
A. No, we weren't.
Q. Are you aware of any analysis done by the state to determine what impacts would occur at Lakes Region because of no UPL payments and no DSH payments?
A. I'm not.
Q. Sir, have there been other rate reductions that Lakes has experienced since 2008?
A. Yes.
Q. Did you compile some data from Lakes in your declaration concerning the impacts of that?
A. I did.
Q. Would you look at your affidavit, Exhibit 76, please? While you're pulling it out --
MR. O'CONNELL: Your Honor, I would offer Exhibit 64 as a compilation of state data under 1006.
THE COURT: Any objection?
MS. SMITH: I don't think you've identified the source of the state data.
MR. O'CONNELL: Oh, okay.
Q. Would you identify for the Court the source data for Exhibit 64, please?
A. It's the New Hampshire Department of

Health and Human Services New Hampshire hospital disproportionate share payments program interim payment plan, December 2011, and the other exhibit is from the Department of Health and Human Services -- New Hampshire Department of Health and Human Services model. It appears to be dated 11-4-10.

Q. And is that information that was provided to the hospitals from the Department of Health and Human Services?

A. Yes.

MR. O'CONNELL: I would offer it again, your Honor.

MS. SMITH: I'm not going to object to it.

THE COURT: The ID may be stricken on Exhibit --

MR. O'CONNELL: That's 64.

THE COURT: -- 64.

(Plaintiff's Exhibit 64 Admitted)

Q. Now, looking at --

THE COURT: I'm sorry to interrupt, but just so -- as I understand from 64, in fiscal 2012 for these ten hospitals there will be no DSH payments?

THE WITNESS: That is correct. There is a

footnote, your Honor, that talks about the state is withholding a total of 500,000 for payment to deemed hospitals. The state hasn't announced which of the hospitals are deemed yet, so I think, other than $500,000, at this point there is no money expected to be potentially distributed to the ten.

THE COURT: Just because I'll forget if I don't ask it now, in the Hood case -- I'm sure you're familiar with it -- there was a provision for, as I understand it, DSH reimbursement payments that covered up to 70 percent of the reduction in the rate, but that's not the case here?

MR. O'CONNELL: Correct.

THE COURT: So here you're demonstrating that not only were their rates reduced but their DSH payments were also reduced. So there's no recovery of any part of the reduction in rates through DSH payments. In fact, the DSH payments were reduced as well.

MR. O'CONNELL: Your last comment you made is right, and that is our position.

THE COURT: What was the last comment I made?

MR. O'CONNELL: The last comment that no DSH payments are being made against the losses that they've suffered.

THE COURT: So if you get a rate reduction, you also have a DSH reduction.

MR. O'CONNELL: Correct.

THE COURT: No percentage of the rate reduction is covered under a DSH payment, and in fact the DSH payments were reduced as well or eliminated in 2012.

MR. O'CONNELL: That's correct.

Q. For the record, let's make this clear. Over here the total UCC payments in 2011 to the ten hospitals is what?

A. 130 -- the difference in the total UCC is 130,121,922.

Q. And the only caveat is there's $500,000 being held aside for some deemed hospitals to be determined?

A. Correct.

Q. It's not 500,000 per. It's a total amount.

A. Correct.

Q. So just to do the math, it would be a $130 million difference year over year and does in

fact go with the $500,000, a little lower?
A. It potentially could be that lower budget amount.
Q. Thank you.
THE COURT: But overall, it's a high percentage reduction.
MR. O'CONNELL: Correct.
Q. And this happened in one year?
A. Correct.
Q. You were given -- strike that.
THE COURT: Since I'm interrupting anyway, you seem to be conflating notice of legislation with notice of rate reduction. Why?
I mean, one might argue -- I'm not sure the state does, but one might argue, of course everybody has notice of pending legislation. Everybody has notice of what the legislature does and the government decides and so forth. Is that what you're addressing?
MR. O'CONNELL: No.
THE COURT: Because they don't relate, do they?
MR. O'CONNELL: They do, but they're not the same thing, so I'll clarify.
Q. With regard to the implementation of a UPL

reduction, what do you believe the state needs to do with regard to CMS?

THE COURT: Well, I can figure that out. What do you mean by they didn't get any notice?

THE WITNESS: That's a question to me?

THE COURT: Uh-huh.

THE WITNESS: In terms of the standard that is required under the Medicaid Act, that was not followed.

THE COURT: You never got any notice of rate reduction or DSH payment reductions?

THE WITNESS: No more than the methodologies. In fact --

THE COURT: I understand all of that but -- all right. Obviously everybody has notice of what the legislature is up to.

MR. O'CONNELL: That's correct. If I conflated it, it was not by design.

Q. The state plan was not amended prior to the enactment of the budget on these issues, was it?

A. Correct. It was attempted to be amended afterwards.

THE COURT: Attorney Smith, I gather it's not the State's position that notice of the budget

legislation is somehow notice of the state plan amendment proposal?

MS. SMITH: No. Because obviously the state plan can't be amended to reflect a change in the budget until the budget is done.

THE COURT: Right. Okay. But I mean it's not your position, you're aware of the budget, you were aware of the reduction contained in the budget, therefore you're aware of the impact on rates because you're aware of the budgetary action. That's not your argument in this case?

MS. SMITH: No. To the extent budget action requires the state plan amendment, we'll show that the state plan amendment was subsequently done.

THE COURT: We all agree that for an adequate state plan amendment you have to comply with the applicable federal regulations.

MS. SMITH: Correct.

THE COURT: Okay.

Q. While you may not have had information about the pending legislation before it was enacted, sir, did you have any information as to how the commissioner intended to change the state plan and how it would affect, therefore, payments

to Lakes?

A. No.

Q. Would you turn your attention to your declaration, Exhibit 76, and specifically table 2? Did you try -- well, strike that.

Before the year over year impact we've just discussed, from 2011 to 2012, can you summarize for the Court the types of other rate reductions that apply to Medicaid reimbursement from 2008 forward? Can you summarize that please?

A. In dollars, it was approximately through -- projecting to the end of the biennium, it's about $11.6 million for Lakes Region.

Q. By category?

A. By category there was a reduction in inpatient rates. There was a reduction in outpatient rates. There was a reduction in the radiology rates. There was a reduction in catastrophic rates. There was a reduction in the payment of cost settlements. That's what I'm referring to in my $11.6 million number. That's based on that.

Q. And let me ask you to look at Exhibit 79 marked for ID. What is this document, sir, Exhibit 79?

A. It's a summary of rate reductions by category for Lakes Region General Hospital for fiscal years 2008 to 2013.

Q. And what is your complaint about the way inpatient rates were reduced during that time period?

A. They were reduced with no notice. It was done by an executive order and implemented a ten percent reduction.

Q. Do you know the timeline in which the executive order was issued and it was ultimately approved by the legislature?

A. It was a matter of days -- or a day.

Q. Was there any public notice before the implementation of the inpatient rate reductions which you're aware of?

A. No.

Q. Did you have an opportunity to comment on the imposition of this rate reduction in Lakes Region?

A. No.

Q. With regard to outpatient rates, what is your complaint with regard to the way they were reduced?

A. They were not only reduced but they were

reduced retroactively.

Q. When was the reduction announced by the state?

A. It was announced in November of 2008 retroactive to July 1st of 2008.

Q. Do you know the process under which that enactment happened?

A. It went through similarly to -- it went through the fiscal committee as a proposal and was adopted.

Q. Was there any public notice of this reduction from the department?

A. No.

Q. Before it was implemented, I should ask?

A. No.

Q. And were you given an opportunity to comment on the impact that it would have on Lakes if implemented?

A. No.

Q. With regard to the inpatient rates, you've calculated a number from 2008 to 2013. Do you see that?

A. I do.

Q. What is that summary?

A. 1,015,000.

Q. Why have you included that number for 2012 and 2013?

A. Because it continues in effect through the biennium.

Q. You haven't experienced those numbers actually yet, though. Is that a fair statement?

A. Right. They're estimates.

Q. Unless something changes, you're anticipating that that will be in effect, or something else?

A. Correct. These are estimates based on holding volume constant.

Q. The outpatient rates reduction from 2008 to 2013 is what number, sir?

A. Is $4,136,928.

Q. The third item listed on this chart is Rev Code 510. What is that reference, sir?

A. It refers to a policy change by the department to no longer recognize, as Medicare recognizes, what might be known as clinic or facility-based services, also known as provider based type payments.

Q. Did that have an impact on the amount of reimbursement that Lakes received by that change?

A. It did.

Q. Do you know when that change was enacted?
A. It was enacted in 2010.
Q. Do you know the process by which it was enacted?
A. It went through an announcement by the department -- just a notice through fiscal committee type of process similar to the other transactions that occurred. We did receive a letter outlining it from the department.
Q. When did you get that letter, sir? Before or after enactment?
A. I guess we got it before actually the payments were reduced. I guess from a legislative history standpoint there was an attempt to eliminate that in a prior year legislatively through the legislative process, but effectively we received a notice after the policy decision was already made.
Q. Were you given a 30-day opportunity to provide written commentary as to the impacts of this change at Lakes Region?
A. No.
Q. The next item is -- oh, sorry. The amount that you have calculated for the period 2008 through 2013 is what, sir?

A. 4,213,492.
Q. The next item is outpatient radiology. Do you see that reference?
A. Yes.
Q. What is the change that you reference in there?
A. The state implemented a change -- it was in common with the 510 code change -- that advised us that they would no longer pay a percentage of cost as defined under what we call a cost report, but rather they would pay us off a fee schedule.
Q. How were you provided notice of that change?
A. The same process as the 510.
Q. Were you given a 30-day opportunity to provide written comments to the commissioner about the impacts of that change?
A. No.
Q. Were you aware of any assessment done by the Department of Health and Human Services concerning the impact at Lakes for that change?
A. No.
Q. How about with regard to the other three items that we just described, any assessment by the department as to the impact at Lakes?

A. No.
Q. And the total for the outpatient radiology impact for the period 2008 to 2013 is what, sir?
A. $497,049.
Q. Have you -- can you describe the next item, which is referred to as catastrophic payments? What does that refer to?
A. It's a policy where the normal inpatient payment would be so below what the actual charges were. There's a certain set of criteria that when the payment was so extraordinarily small that there would be a small supplemental payment. It's also sometimes known as kind of like an outlier payment. And the last time we received those was the figures that are on the chart here.
Q. What is the process by which that change was implemented?
A. It follows a similar pattern as the others. It's basically a policy decision brought through the legislature. But we didn't get to participate in any process that conforms with the Medicaid requirements.
Q. Were you given a 30-day notice to provide written comments?
A. No.

Q. Were you aware of any assessment done by the department as to the impacts of this change at Lakes?

A. No.

Q. And the total for that catastrophic payment reduction for the period 2008 to 2013 is what?

A. 446,032.

Q. The last item refers to outpatient settlements. What is the issue with regard to outpatient settlements?

A. The hospitals file a report called a cost report and that defines the costs that we've incurred in treating Medicaid patients using a methodology that CMS uses to define Medicare cost. And on an interim basis the state pays hospitals a percentage of what they bill, and then there's sort of what we call a true-up where they compare what they paid versus what would be a percentage of cost, which is currently for the ten hospitals at 54.04 percent of cost. So they compare what they paid on an interim basis with what that 54.04 percent of cost is as defined under the cost report, and if there's a balance that's owed to the provider, which is the case with Lakes, that

money is supposed to be what we call settled or paid to the provider.

Conversely, if a provider -- if they've paid the provider too much, the provider would owe money back to the state.

Q. And do you have any commitment from the state as to when those outpatient settlements will be paid to Lakes?

A. As I understand the budget that was just adopted, they talked about paying it in some future fiscal year with no commitment as to when it would be.

Q. So as you sit here today, do you know when you will get that cost settlement from the state?

A. We do not.

Q. What is the impact of that administration of that issue with regard to outpatient settlements?

A. Effectively, we're loaning the state, according to my chart, about $1.26 million.

Q. What was the process by which that cost settlement process was changed?

A. The process wasn't in effect changed. It was suspended. In other words, whereas they ordinarily would pay out the settlements or

receive the payments, that to my understanding any cost reports that are sort of '09 forward aren't going to -- haven't been settled.

Q. Were you provided any notice of the suspension of that administration?

A. No.

Q. Were you given an opportunity to comment as to what the impacts would be on Lakes?

A. No.

Q. Did the commissioner or anyone on his staff inquire of Lakes before the implementation as to the impact at Lakes?

A. No.

Q. And the total for these category rate reductions for the period 2008 through 2013 is what number, sir?

A. $11,570,022.

Q. How does that relate to the numbers that you're describing with regard to Exhibit 64?

A. Well, Exhibit 64 magnifies the impact of these compounding rate cuts.

Q. So the numbers that are referenced on 79 are independent of the rate cuts referenced in Exhibit 64?

A. At the totals line level, yes.

Q. There's a reference on Exhibit 79 to the upper payment limit?
A. Correct.
Q. That was actually covered in Exhibit 64; is that right?
A. Correct.
Q. What was the source of the data from which you compiled this chart?
A. A number of internal sources. Do you need me to walk through each of them or just the general --
Q. Just generally. Was it done under your supervision, sir?
A. It was done under my supervision using either, in the case of like inpatient rates, the rate in effect times the number of discharges that we had in a particular year.
Q. Is it based on Lakes Region data?
A. It's based on Lakes Region specific data and Lakes Region cost report information.
Q. Do you believe it's accurate?
A. I do believe it's a reasonable estimate, yes.
MR. O'CONNELL: I would ask that Exhibit 79 have the ID stricken, your Honor.

THE COURT: Any objection?
MS. SMITH: I'm sorry. I'm having trouble hearing him.
MR. O'CONNELL: Oh, I'm sorry. I would like to strike the ID from Exhibit 79.
MS. SMITH: I'm not going to stipulate to the accuracy, but I will not object to the document coming in.
THE COURT: ID may be stricken on Plaintiff's 79.
(Plaintiff's Exhibit 79 Admitted)
MR. O'CONNELL: One second, your Honor.
Q. Mr. Lipman, I would like to change your attention to Exhibit 79, outpatient radiology line item. There was a development last week on that subject, wasn't there?
A. Yes, there was.
Q. Would you describe what happened last week, please, for the Court?
A. The hospitals' CEOs received a letter from commissioner -- from the Commissioner of Health and Human Services advising that they had been in discussions with CMS about SPAs, state plan amendments, that had previously been filed which was not approved by CMS and were advised that it

was never the state's intent to convert it to a fee schedule now that they understand that by doing so would mean that those dollars weren't subject to taxation for the MET matching program, the Medicaid enhancement tax.

THE COURT: No hope.

MR. O'CONNELL: No.

Q. Yeah, I don't think we need that level of detail, Mr. Lipman. Let me ask you another question.

Has the state taken a position as to whether the outpatient radiology reductions are still in effect?

A. They've taken a position that they're going to reverse them.

Q. Do you know when you will receive the payments that are referenced on Exhibit 79?

A. There was an indication of it being a six to eight week type of time frame.

Q. So at least with regard to that item there's been a change in the way it's being administered by the state, true?

A. Yes.

THE COURT: Outpatient radiology?

MR. O'CONNELL: Correct.

Q. And so if it is in fact reversed at sometime in the future, you would need to reduce this chart, Exhibit 79, by the amount for outpatient radiology for it to be accurate, correct?

A. Correct. By $497,049.

Q. But as you sit here now, you don't have that money and it's been administered this way since 2008?

A. Correct.

Q. Does Lakes generally receive full reimbursement for the Medicaid services that it provides to patients?

A. No.

Q. Have you calculated what actual cost ratios Lakes has received, or LRG Healthcare generally, for the types of services it provides?

A. Yes.

Q. Is that information contained in your declaration, which is marked as Exhibit 76 for ID?

A. Yes.

Q. Okay. Would you look at table 2 on page 6, please? Would you describe for the Court what is calculated here?

A. It's simply looking at the costs that we

incurred in providing care, comparing it to the payments, looking at that net difference and calculating what we would call a payment to cost ratio.

Q. And so in 2006 for inpatient services what was that cost ratio?

A. We received -- our payment was worth about 49.8 percent of our actual cost.

Q. So is it fair to say that would be 49.8 cents on every dollar of cost?

A. Correct.

Q. And for 2007 what happened to that rate reimbursement for inpatient services?

THE COURT: Why is that relevant? I mean, inflated costs, you know, nobody pays that.

MR. O'CONNELL: Reduction over time, your Honor. And I believe the state's position is going to be that these are institutions that can afford to absorb the cost. If that's not going to be the legal analysis this Court applies, I can move on.

THE COURT: Well, but it's all related to the reduction in the rates. I assume the starting presumption is things were fine the way they were. It's the change that's unacceptable.

MR. O'CONNELL: And it's been changing over time. That's the only point I --

THE COURT: But the change is a function of this is what we used to reimburse. This is what we do now. That's not acceptable. The starting point is it was acceptable, right?

So what difference does it make what somebody says it costs to give you a bandage. Ten dollars for the Band-Aid. Well, maybe it is. Maybe it isn't. What difference does it make? You got reimbursed three dollars for it. Now you're getting 50 cents. That's the issue, isn't it?

Q. Mr. Lipman, is it fair to say, as the Court has summarized --

A. No, it's not. It's a common misconception in the public.

What we're really talking about here is the true cost. So whatever our acquisition costs were for the people that we paid out, the actual cost of the Band-Aid, not any -- what we're talking about here is --

THE COURT: I've paid for a lot of expensive Band-Aids.

A. But what we're talking about here is not

the standard comparing it to what would be like published retail rates but actually to the true accounting costs as defined by the federal government in terms of what are allowable costs.

So it reflects our -- when you look at any expense item, like labor, it reflects what we paid people in their weekly paychecks. It reflects what we paid Public Service of New Hampshire for electricity. It reflects true costs, not what would be, you know, when you shop or look for --

THE COURT: No. I understand, but there's all kinds of indirect overhead that's factored in, and flowers on Secretary's Day gets factored in, and every expense that you can put in there and amortize and all of that. I understand all of that.

But here -- isn't the issue here that you were getting a particular Medicaid reimbursement rate, and that was fine, and now you're getting a particular lower Medicaid reimbursement rate and you're claiming that that's not fine because we can't live with it, right?

But whether what you claim is your actual cost, factoring in every cost you can possibly assign to a particular Band-Aid, that's not really

relevant here, is it?

THE WITNESS: Well, I think it is actually, your Honor, because I think -- as I understand how CMS evaluates and monitors the adequacy of the reimbursement rates is that they have to have some relationship to cost and --

THE COURT: I thought the claim here was we never got that far. I thought that was your claim, we never got the opportunity to make the case. So whatever the case is is sort of irrelevant, isn't it? It's we never got to make the case.

MR. O'CONNELL: I will accept that. And when the state tries to offer information about the ability of these hospitals to fund these reductions, I'll get up on my feet and object because that's the flip side of this issue, whether they have the ability to establish margin to be absorbing these losses on a year over year basis. That's the issue I --

THE COURT: I know. I take your point. It never occurred to me that we were going to be litigating whether or not they actually have the ability to absorb the cost.

MR. O'CONNELL: We don't think we should

be, your Honor. We've just seen it in the papers and are prepared to address those issues, but we could call Mr. Lipman back and --

THE COURT: I'm not sure how we could litigate that on a preliminary injunction hearing anyway. That would take a long time.

MR. O'CONNELL: That would take a long time, your Honor. I believe that's true.

One issue that just was addressed by the Court that I would like to clarify with this witness --

Q. Is there a difference between what you described as cost and charges?

A. Yes.

Q. Would you please describe that for the Court?

A. The charges are developed to above the costs that create an opportunity to make a margin, and so if you only --

THE COURT: I think at Concord Hospital I paid $38 or something once when I was in there overnight for a cup of mushroom soup. Now, is that a charge or is that a cost?

THE WITNESS: That's a charge. And it might reflect that ten people before you weren't

able to pay anything for their soup so they have to set the rate to recover it.

THE COURT: And what you're talking about here -- you're saying the costs.

THE WITNESS: Correct.

THE COURT: As opposed to charges.

THE WITNESS: Correct.

Q. So that wouldn't include the example the Court gave of flowers that would get amortized for the Secretary. That's not a cost, is it?

A. Medicare has a definition of what are allowable costs, and it typically would exclude things that are not considered important to delivering patient care.

Q. Okay. I would like to turn your attention to the last topic. Once you learned of the financial impacts that you would be dealing with as a result of the budget change and the over time changes, what process did you go through at Lakes to determine how to deal with it?

A. Well, we -- I guess, in summary form, we looked at a number of different options that we could potentially consider on a management team level first.

So, for example, obstetrics is a service

that we provide to our community. We're one of the last remaining -- we're the only source of obstetrics care in Belknap County, and within our region one of the last to be providing obstetrics, delivering babies. And that service runs anywhere from 50 to 60 percent of our patients are Medicaid, and for each Medicaid delivery we lose approximately $7,000 over our cost for each baby that we deliver.

We considered whether we could do that but ruled that out because there is no option in our community if we no longer do that.

Q. What did you actually -- after you did the consideration that you described, what did you decide to do at Lakes to meet the financial circumstances that confronted you?

A. We did three things. One has been implemented, one's in the process of being implemented, and another is in development to be implemented.

The discharging of adult Medicaid patients from our practices, the adjustment to our charitable care program and the addressing elective -- or avoidable elective care.

But just to put it in context, it goes

back to the four buckets I talked about earlier. You know, we've exhausted reduction in profitability because we're running in the red. We've pretty much exhausted what we can do in terms of cost shifting. The largest payer in the state has taken a position that they won't absorb any of these Medicaid losses. We've worked with other hospitals to try to improve our efficiencies, and internally ourselves, and we've been left to deal with access as being really the remaining area to try to help overcome the large deficits that we're under.

Q. With regard to the closure of the primary practices to Medicaid patients, what do you believe the total impact will be in numbers for the Medicaid population?

A. The number of letters that we sent out was 3,000, approximately, and we have approximately 87 percent of communities' primary care providers are associated with LRG Healthcare. We would expect some percentage of those patients, as well as -- you know, we saw earlier there are 9,000 people that are kind of rolling in on Medicaid. That there will be increasing challenge in terms of establishing a regular source of primary care. I

think that's --

Q. What do you believe the impacts would be -- what are you planning for the impacts to be at Lakes because Medicaid patients will no longer be treated by your primary care physicians?

A. Well, in terms of how it will affect the institution? Is that your question?

Q. Yes.

A. By adjusting the volumes -- we basically are able to provide those services by cross-subsidizing from plus margin services. By reducing the utilization rates we hope to be able to readjust our operations to be able to effect our cost structure.

Q. What do you anticipate the impacts will be with regard to the Medicaid patients that will not be seen?

A. I think the Medicaid patients in our community are now at higher risk for morbidity and mortality because you can't go from a primary care base of 40 something to maybe six and that there not be any impact in terms of the timeliness of preventative monitoring of services, trying to affect the incidence and prevalence of chronic disease, what have you. I think that our

population is at higher risk in our community now for morbidity and less well-functioning disability. And ultimately when chronic conditions are not well managed it can shorten someone's life expectancy.

THE COURT: 40 to six what?

Q. Could you please explain to the Court what that 40 to six reference was?

A. Within our LRG Healthcare structure we have 40 primary care providers, internists, family practitioners, nurse practitioners, who were serving the population that were discharged from the practices.

Outside of that, there are six people who are, if you will, in independent practice. And I would add that that constitutes two family practitioners that are in separate locations. If you want me to get into the details of it --

Q. Okay. Thank you, Mr. Lipman. The state has taken a position -- and finally to close out here -- that it's your choice to limit these services. The phrase they have used in the pleadings in this case is "vote with your feet". Has that been the experience that you have had at Lakes Region after you announced these changes?

A. No.

Q. What has your experience been? Please describe that for the Court.

A. The Governor made a public statement that could be characterized as criticizing our board of trustees and hospital management for abandoning its mission. He asked that the Attorney General's Office investigate our charitable status, which has been initiated. There were also other interaction of public officials in our community with community leaders trying to get people to apply pressure to us to reverse -- or just plain put pressure on us.

Q. With all that, Mr. Lipman, why are you taking the actions of limiting care as you described them?

A. Because we have to. Ultimately it's -- it comes down to this. We have our operating margin, our resources, to serve our community. We've been operating in the red. We finished fiscal year 10 $2.2 million in the red.

THE COURT: I'm sorry. Fiscal year what?

THE WITNESS: Fiscal year 2010.

THE COURT: When was the last time the hospital made a profit? Well, if you could just

cover that briefly. What's the fiscal year? How do you account for the profit? When was the last time you were profitable? What was it? What's the history?

Q. What's the hospital's fiscal year?

A. It's the same as the federal fiscal year, so it goes from 10-1 to 9-30.

THE COURT: September to October?

THE WITNESS: Yeah.

Q. It's different than the state's fiscal year?

A. The state's fiscal year goes July 1 through June 30th.

Q. The Court asked when was the last year you had an operating profit.

A. Fiscal year 2000.

Q. And what is the current deficit you're dealing with?

A. We haven't completed our fiscal year 11.

THE COURT: I'm sorry. Fiscal year 2000? 2000?

THE WITNESS: No. 2009.

THE COURT: 2009.

THE WITNESS: It was approximately $1 million.

A. If I could, just to take the --
Q. Please describe it.
A. Before the rate cuts came into effect, the hospital had approximately a 2.2 percent operating margin, which was approximately $4 million in 2008.
In 2009 it dropped to approximately a million dollars, which can't be fully attributable to the Medicaid cuts, but when you look at the year over year impact and the rate reductions --
THE COURT: I'm only asking because it goes to counsel's point about the ability to absorb.
A. Sure. So then in fiscal year 10 we ran a $2.2 million operating loss. In fiscal year 11, which is not subject -- it hasn't -- the audit hasn't been completed so --
THE COURT: Well, operating loss -- you know, when you get into these accounting terms you can get into the woods here.
Using the same uniform standard, give me the numbers as you report to your board, for example.
THE WITNESS: Sure. Net income line -- income from operations is the statistic I'm using,

and net income would be familiar to the Court.

THE COURT: Net income is an arguable concept as well, but what do you report to your board? Hey, we did well this year. We're in the black. What number is that?

THE WITNESS: We report two numbers. There's two indicators. One indicator is what we call operating margin. And the other indicator is called total margin, okay?

For the year that we completed in 2010, the operating margin was a negative 2.2. The total margin was actually about a $13 million negative number, okay?

And in fiscal year 11 we're projecting that due to some one-time situation that we may actually do a little bit better than fiscal year 10. But our structural deficit for fiscal year 11 operating margin is approximately about $4 million.

And our projection for fiscal year 12 is that we're dealing with an operating margin deficit somewhere between 8 and 12 million that we're trying to adjust for.

THE COURT: Thank you.

MR. O'CONNELL: One second, your Honor.

Thank you, your Honor. Nothing further at this time.

THE COURT: All right. Thank you, Mr. O'Connell.

Attorney Smith, maybe we should take a break.

MS. SMITH: Maybe we should take a short break?

THE COURT: Take a short break, yeah.

(RECESS)

MR. O'CONNELL: Your Honor, briefly before we begin, an internal issue.

THE COURT: Sure.

MR. O'CONNELL: The state and -- Ms. Smith and I talked about exhibits. We're going to move -- stipulate to admission of all of the affidavits and declarations that are before the Court. We'll take care of that administratively off the record. I was going to ask for an opportunity to do that with Mr. Lipman, but it's unnecessary. Thank you.

MS. SMITH: Yeah, we're just going to stipulate that all of our declarations submitted for the preliminary injunction are marked in full, as are all of theirs.

THE COURT: All right.

CROSS-EXAMINATION

BY MS. SMITH:

Q. Good morning, Mr. Lipman.

A. Good morning.

Q. I'm Nancy Smith from the Attorney General's Office.

You talked to Attorney O'Connell about actions LRG has taken dismissing some Medicaid patients from your primary care practices, correct?

A. Correct.

Q. Now, these are doctors' offices, correct?

A. Correct.

Q. And these are practices that LRG owns, correct?

A. Correct.

Q. At the department's request after you had taken that action you sent a list of the actual LRG practices that LRG was dismissing Medicaid clients from to the department. Are you aware of that?

A. Yes.

Q. And there's a container of notebooks up there on the witness stand with you. If you could

look at Exhibit 198? We're also going to pull it up onto the screen, but since it's a multipage document it might be easier for you to take a look at in the notebook.

A. It's listed as Exhibit 198?

Q. Pardon?

A. Tab 198?

Q. 198. And have you found Exhibit 198, sir?

A. I have.

Q. Is that the list of practices that LRGH sent to the department as being those that were letting Medicaid clients go?

A. It's both the practices and the providers identified, yes.

Q. And that's in the chart that is attached, correct?

A. Correct.

Q. So looking at that chart -- as you said, this is primary care only, correct?

A. Correct.

Q. And are you aware that Medicaid recipients don't have to designate a primary care doctor?

A. Yes. But I think it's -- as any patient under many insurance plans, people do tend to choose a regular source of their primary care. So

I think that's fairly common practice.

Q. And to the extent that LRGH owns specialist practices, those can still accept referrals for Medicaid patients, correct?

A. Yes. However, as I testified earlier, as it relates to specialty care one of the other aspects that we're looking to implement is a limitation on what we're calling avoidable elective procedures.

Q. And is that -- so the office visits to these primary care practices that have taken this action, those would have been billed as fee-for-service doctors' offices visits, correct?

A. Correct.

Q. So those are not on the inpatient rates list we're talking about here, correct?

A. That is correct. However, I think the important point to note here is that our name, LRG Healthcare, connotes a system and that we cross-subsidize physician care based on positive margin services and the hospital system itself.

Q. But the doctors' offices fees are not on the inpatient rates that we're talking about or the outpatient rates, correct?

A. That is correct.

Q. So you've dismissed patients from -- your Honor?

THE COURT: I thought what he was saying was, if you reduce our income in these areas to this degree we can't support Medicaid patients in our primary care practices.

Q. But the rates that are paid to these physicians are not the rates that you're complaining about having been reduced, correct?

A. That is correct. Those are the --

THE COURT: No. He's saying it's an impasse. In other words, we no longer are able to -- I think we're all getting a little too far down the road on the merits of whether or not this is a good change or not, I suppose. The issue really -- well, I suppose it's a 30(a) claim, isn't it?

MR. O'CONNELL: It is, your Honor.

THE COURT: But I think that was the point. We can't do it. You haven't taken into account the fact that a substantial amount of the Medicaid patient population will be disenfranchised from the services if these rates are in effect. I think that was the point.

THE WITNESS: Yes.

MS. SMITH: We'll be discussing that in just a second.

Q. LRG -- did you participate in providing a letter to your LRG practices that they were going to send out? Have you seen that letter?

A. Yes, I have.

Q. And if you can turn to Exhibit 181? It should also be on the monitor in front of you. This is a one-page document, so maybe that would be easier.

A. Yes.

Q. This isn't addressed to any specific person, but have you -- do you agree that this is an example of the letters that LRGH sent out to its 3,000 Medicaid clients?

A. Yes. It's the template version of what we sent out.

Q. And in this you list four practices that you know were still accepting Medicaid clients that are also primary care, correct?

A. Correct.

Q. And two of those, Westside and Newfound Family Practice, are owned by LRGH, correct?

A. Correct. They're owned by LRGH, and they also have the distinction of being classified as

rural health clinics, which is a distinction reflecting a certain uniqueness with respect to how they're reimbursed to ensure access.

Q. And so those two practices get reimbursed at a much higher rate, correct?

A. That is correct.

Q. And those two practices still had capacity to accept patients?

A. Some capacity, yes.

Q. And the other two practices, the Health First facilities that you list here, are you aware that those also have a designation as -- or have a designation as a federally qualified health center?

A. Correct.

Q. And all four of those are required in order to have those designations and get those higher rates that they accept all Medicaid patients, correct?

A. Within the capacity of their provider panel size, yes.

Q. And are you aware that Lakes Region's CEO, Mr. Claremont, is also treasurer of the healthcare corporation?

A. Yes. As well as Lakes Region General

Hospital, or LRG Healthcare, provides approximately a 220,000 a year subsidy to help Health First exist, and that was one of the issues that we considered in terms of the options is whether to eliminate that or not.

Q. If you could look at Exhibit 190, are you familiar with press coverage of LRGH's actions after those actions were announced?

A. Yes.

Q. And this appears to be an article that was posted on citizens.com that appeared in a Laconia newspaper, correct?

A. Correct.

Q. And your CEO, Mr. Claremont, if you go down to the bottom part of this, is quoted as saying, "There is capacity in the general area for affected Medicaid patients to get the services they required, said Claremont, and LRGH has been steering patients into it", correct?

A. It does say that. I think it would also be fair to say that the executive director of Health First said they had a capacity at the time of approximately 600 patients and that the two centers, excuse me, the rural health clinics had some capacity as well, but probably less than

that, and that we were trying to help people to the best that we could to get a source of primary care where it was available. But that only takes into account the people who are currently now enrolled. It doesn't take into account those to be enrolled in the future.

Q. Going back to your declaration, actually -- I'm sorry to be skipping around from documents, but that's Exhibit 77 and it's in paragraph 5 of your November declaration. That's not going to be in ours. We'll pull it up on the screen for you. It's one of the plaintiff's exhibits.

MS. SMITH: If I can approach, your Honor?

THE COURT: Anytime, Attorney Smith.

Q. So if you can go to -- I believe it's paragraph 5 of that document.

A. Yes.

Q. You've indicated that in deciding who to send this letter to you reached back three years and seven months?

A. That corresponded with a computer system conversion for us in terms of our physician practices, and we wanted -- not having a way to know who is currently eligible on Medicaid in any

administratively efficient way, we identified those patients who have been on Medicaid within those practices for that time period.

Q. So you would agree, wouldn't you, that this may have gone to a lot of people who were no longer on Medicaid?

A. I would say that there's some that wouldn't be. I honestly can't estimate whether it's -- what percentage it would be.

Q. So if the department was -- and you actually provided a list of names of who you sent the letters to, correct?

A. We did. To the commissioner.

Q. If the department was able to take that list and cross reference it against currently enrolled Medicaid folks and determined that somewhere maybe in the range of a thousand people out of your list of 3,000, over 3,000, were currently on Medicaid, you were overinclusive by two-thirds, correct?

A. I don't agree with the characterization of overinclusive because of the substandard nature of the communication that we would rather over-communicate than under-communicate, but the fact that the state may have found fewer than the

3,500 is not entirely surprising, correct.

Q. But if the department's research indicated it was something around a thousand or less, you have no basis for disputing that, correct?

A. I do not have a basis for disputing that. I would like to add, though, that even if a person didn't have a change -- I mean, if they would have to change a position, which is also an impact that goes beyond just even not having a position.

MS. SMITH: Do you have any objection to striking the ID on Exhibit 198?

MR. O'CONNELL: No objection on 198, your Honor.

THE COURT: ID may be stricken on Defendant's 198.

(Defendant's Exhibit 198 Admitted)

MS. SMITH: Do you have any objection on striking the identification on Exhibit 181?

MR. O'CONNELL: It's a full exhibit already.

MS. SMITH: It's full already.

Q. And you're aware that there's a John Doe plaintiff in this lawsuit as a Medicaid recipient --

A. Yes.

Q. -- who has received services at LRGH?
A. Yes.
Q. And I would like you to look at what we've marked for identification as Exhibit 197, which only identifies him as John Doe. Have you ever seen claims data from the department before?
A. I don't typically deal with that level, but I have in my career, yes.
Q. Okay. I'll represent to you that this is claims data from the John Doe plaintiff in this lawsuit and it lists a couple of -- several providers on the first page of this.
And if you could look at that list and compare it to the provider list that LRGH sent us, which is Exhibit 198, isn't it fair to say that the providers that he is listed as having seen are not any of the providers that dismissed patients, except for one entry for a nurse practitioner at Belknap Family Practice, correct?
A. That would be correct.
Q. And I may mispronounce the names, but the doctors that he's seen on -- apparently seen on a regular basis, Dr. Mahadevan and Dr. Friedlander, are not on your list of practices that have dismissed patients?

A. Dr. Friedlander is listed here as internal medicine. He's actually a hematologist, oncologist. Dr. Mahadevan doesn't practice at our facility.

Q. So he's an independent?

A. I suspect he's at another facility not associated with us at all.

Q. So to your knowledge the John Doe plaintiff has not been dismissed from his physician practices, correct?

A. He has -- with respect to treatment -- that there's a continuation of treatment for specialty care for all patients.

Q. So the answer to my question is he hasn't been dismissed from the physicians he's listed here as having seen at Lakes Region, correct?

A. Correct.

Q. Going back to one other exhibit you looked at, Exhibit 190, which is the press release.

MS. SMITH: Do you have any objection to striking the ID on that?

MR. O'CONNELL: It's not a press release. It's a news article. And it's hearsay and we object.

Q. You don't have any basis for disputing

that your CEO, Mr. Claremont, made the statements listed in this document as quoting him, do you?

A. The answer I would say is no, but it's also fair to say that I don't know that these quotes are verbatim.

MS. SMITH: I would move to have it admitted -- the ID stricken as a party admission.

THE COURT: Objection?

MR. O'CONNELL: Objection, your Honor. It's hearsay.

THE COURT: Objection overruled. It's an admission by a party opponent. ID may be stricken on Exhibit 190.

(Defendant's Exhibit 190 Admitted)

Q. And as the chief financial officer of Lakes Region, are you familiar with how much Lakes Region claims on -- you file tax reporting forms with the IRS every year, correct?

A. Yes, the 990.

Q. And they're called 990s?

A. Yes.

Q. And you're familiar with those forms?

A. Generally, yes.

Q. Your name appears on them?

A. I sign them, yes.

Q. If you could look at Exhibit 146, do you have that in front of you?
A. I do.
Q. And is this the most recent 990 that Lakes Region has filed?
A. Correct.
Q. And this is listed as the IRS year 2009, correct?
A. Correct.
Q. But it covers the period October 1, 2009 to September 30, 2010?
A. Correct.
Q. And going down to the bottom, you submitted this -- did you sign this document?
A. I did.
Q. And you submitted it on August 15, 2011?
A. I did.
Q. And to the best of your knowledge are the figures related to the financial status of Lakes Region Hospital that you represent in this correct?
A. Yes, but only insofar that it should be acknowledged that the 990 does not follow generally accounting -- GAAP principles. So there are variations between what you would find in an

audit report and here based on how the IRS asks for us to complete information, but the information that's contained in here is from our audit reports.

MS. SMITH: I would ask that the ID be stricken.

MR. O'CONNELL: Objection. Relevance, your Honor.

THE COURT: Overruled. The ID may be stricken on 146.

(Defendant's Exhibit 146 Admitted)

Q. Going to I believe it's page 10, it's part number 9, and I believe it's line 11(d), does that -- do I have the right page?

A. 11(d) would be the lobbying line. Is that what you're referring to?

Q. Yes.

A. Yes.

Q. I'm just trying to catch up with you on my computer. Does that show a figure that Lakes Region claims it spent in this fiscal year -- the fiscal reporting year for lobbying expenses?

MR. O'CONNELL: Objection. Relevance.

THE COURT: Well, you know, I think we're going to spend a lot of time on the 30(a) claims

we probably shouldn't spend. But it's relevant, is it not, if -- and I think the state's position is you can absorb these costs. Isn't that your position?

MS. SMITH: It also goes to the notice issue, as they claim they didn't have opportunity to comment and they're spending very large sums of money on lobbying at various levels. So I think it's very relevant to the notice issues and their claims that they had no opportunity to comment.

THE COURT: I'm not sure it's relevant for that. I mean, they're lobbying all kinds of issues. I thought it was going toward their ability to absorb the rate reduction.

MS. SMITH: I understand they have two baskets of claims. If I'm wrong and there's only one issue here --

THE COURT: To the extent it goes to the notice, inadequate foundation, objection sustained.

If you're offering it as some sort of evidence that requisite notice was given of the rate reductions, the objection is sustained. There's inadequate foundation. I mean, generic lobbying on behalf of a hospital?

MS. SMITH: Well, I planned on asking him more questions about --

THE COURT: We call that a foundation. If you lay a foundation, we'll think about it again.

MS. SMITH: All right.

THE COURT: But not lobbying off a form in a generic sense.

Q. Does Lakes Region use lobbying?

A. I think the expenses that you're seeing reflected here are primarily those portions of our American Hospital Association and New Hampshire Hospital Association dues which for reporting purposes have to be classified as lobbying.

I do not recall in that fiscal year that we had a separate lobbyist beyond that. If we did, it was not material.

Q. So you are a member of the New Hampshire Hospital Association?

A. Yes.

Q. And does the hospital association speak on your behalf in various venues?

A. They do.

Q. And they're authorized to do that?

A. Yes.

Q. And they show up at legislative hearings

and say they're representing all of the hospitals?
A. They do. But I would comment that with respect to the 2008 outpatient reduction -- as an example, we got an e-mail from the president of the hospital association advising us that they were completely surprised by the rate reduction that was implemented.
Q. We'll come back to that.
A. Okay.
Q. And we'll give you more opportunity to talk about that.
Just looking at another -- so part of what you claimed was lobbying does support the New Hampshire Hospital Association and their going to various venues and making comments on your behalf about various proposed rate reductions?
A. Yes. I think in general, but to represent the impacts on our particular community I think they would need to involve us in that specifically.
MS. SMITH: Okay. All right. I think we've laid a foundation that the lobbying expenses they claim are at least partially attributable to the carving process, and I would ask that the ID be stricken.

MR. O'CONNELL: Objection, your Honor.
THE COURT: Sustained. Not from this witness. I think he just said the opposite.
MS. SMITH: Okay. All right.
Q. In addition to the $1,006 on page 10 in Schedule C of your 990 --
A. What page is that?
Q. I believe it's on page 17 of 76.
MR. O'CONNELL: I'm sorry. Can you tell me where the page reference is?
MS. SMITH: Pardon?
MR. O'CONNELL: Where is the page reference, Ms. Smith? I'm not sure I'm following you. Can I look at what you're looking at?
MS. SMITH: If you look at the computer, it has the total number of pages.
THE COURT: Just going back to what I asked you a while ago, I thought it was not your position that notice of the legislative process, or the budgetary bill that was going through the legislature, that didn't constitute -- that wouldn't constitute notice as required under the Medicaid Act.
MS. SMITH: Well, he testified that they had no opportunity to comment before the budget

got passed and --

THE COURT: No, no. Again, you're both conflating the budgetary process with what the federal Medicaid statute and implementing regulations require.

In my mind they're two completely different things. They may be joined at the hip in functional ways, but I thought we agreed earlier in the morning that it was not the state's position that knowledge of the budgetary process, the legislative effort and the impact that would have, that doesn't constitute notice of a plan amendment.

MS. SMITH: Of a plan amendment, no.

THE COURT: Or a proposed plan amendment.

MS. SMITH: But it does constitute notice of the planned reductions because the reductions are set out in the budget process and then they --

THE COURT: But how does that help you? How does that help you if that's not adequate notice under the statute or the implementing regulations?

MS. SMITH: It goes to his testimony that they have had no opportunity to provide comment about the affect --

THE COURT: Yes, but it's, I had no opportunity to provide comment as provided for by the federal statute in implementing regulations which requires prior notice of an intent to reduce the rates which triggers an opportunity to comment.

And you seem to be falling back to, well, you knew the budget was in process. You knew the budget impact would be X. Of course you could have commented.

Yeah, I guess you could in space or in public venues or write letters to the editor or whatever, but that's not the kind of comment we're talking about here, is it?

MS. SMITH: On something -- I think we have to distinguish between actions. On some actions for which there needed to be SPAs, state plan amendments, then there was a separate notice period specifically for the state plan amendment.

For something that we think we arguably didn't have to take the state plan amendment that had an affect on rates but they were within the current methodology -- because the methodology is in the state plan, not specific rates.

So we contend that the legislative

process -- and that's not the same notice process as required for SPAs, and we do contend that the legislative process can provide adequate notice under the federal regulations for a rate change that doesn't require a SPA because it's within the current methodology.

THE COURT: All right. That clarifies what I thought we had agreed to earlier, which was different, but okay.

MS. SMITH: I understood the earlier questions to be focused on the recent budget cycle in 2011 about the changes to DSH and UPL, and there have been SPAs about both of them.

THE COURT: Okay.

MS. SMITH: So I would like to proceed with this line of questioning.

THE COURT: Certainly.

Q. The page that I directed you to in the 990, which I believe is page 17 out of 76, in Schedule C, II(a), and this page is about the lobbying expenses by LRG, correct?

A. Correct.

Q. Could you explain what other lobbying expenses, other than the 106,000 that we talked about before, LRG is also indicating it had on

this page?

MR. O'CONNELL: Objection. Relevance, your Honor.

THE COURT: Overruled.

A. What is being calculated here is a limitation by the IRS as to what can be excluded for purposes of falling below the threshold. In other words, I guess what we're documenting here is that LRG Healthcare didn't spend an amount on lobbying that would exceed the threshold where we would have to pay a tax on it. That's what I think we're looking at here.

This is just a formula for the deriving -- the amounts that would be nontaxable we could have spent a million in each of the '06 through '09 years.

Q. So you're not -- just so I'm clear, this does not indicate that you spent additional monies over and above the 106,000 in lobbying expenses?

A. That's my understanding of it, yes.

Q. And are you listed in this 990 as being one of the highest paid officials at LRGH?

A. Yes.

Q. And it lists your salary as being in total just short of $270,000, correct?

A. That's total compensation, yes.
Q. Going to your first declaration -- just let me find the exhibit number on that. I believe it's Exhibit No. 76. That wouldn't be in those white binders. Those are our exhibits. This is a plaintiff's exhibit.
MR. O'CONNELL: Yes, it's 76.
THE COURT: Just for your planning, I thought we would go to 12:30, if that's all right, and then we'll resume again at 1:30.
MS. SMITH: Sure.
Q. Do you have a copy of it?
A. Yes.
Q. In table 1 of that document you indicate that the total Medicaid revenue in 2010 was $43 million, correct?
A. I do in 2010.
Q. Let me just catch up to you, sir. If you look at table 2, let me just move some of these exhibits. So looking at table 1, you say -- total Medicaid in 2010, table 1 says the total is 43.3 million, right?
A. Yes.
Q. And in table 2 you indicate the total Medicaid payments for inpatient in the same year

was 1,757,000, correct?

A. Correct.

Q. That's the figure you gave us, 1,757,331 in table 2?

A. Correct.

Q. For Medicaid payments for inpatient?

A. Correct.

Q. And in table 3 you indicate that outpatient Medicaid payments for the same year were 3,501,676, correct?

A. 679.

Q. 679?

A. Yes.

Q. Okay. And in table 4 you indicate that your physicians' Medicaid payments were 2,680,985; is that correct?

A. Yes.

Q. So these total up to 7,939,995, I believe.

A. That's close -- pretty close.

Q. Does that look about right?

A. Pretty close.

Q. Do you want to do the math? Go right ahead.

A. Yes, I agree with the figure.

Q. And so you got paid 35 million more in

Medicaid revenue than your Medicaid payments, correct? That's what you said by your tables.

A. No, I didn't, actually. I think that with respect to the payments the 7,939,995 is what we received in cash payments from Medicaid.

With respect to totally Medicaid revenue, that represents the gross charges that were billed to Medicaid. It doesn't -- it's a concept of, if you will, what our published charges were. That's what that total is.

Q. So when you say your business revenue, you're not being accurate, correct?

A. No, I am being accurate. There's net revenue as opposed to gross revenue. We're talking about gross revenue here.

Q. So your gross revenue would include monies by insurance companies that you don't get paid because they don't pay you the full charges billed either, correct?

A. Well, I think we've got to take a minute to get the concept of revenues down. There's gross revenue which is -- so that we have a uniform rate to value what is provided. And then there are net revenues, which are what we talked about. It would be what the insurance company

pays us and what Medicaid and what people don't.

Q. You just told us that table 1 in your declaration, as far as revenue figures, are gross figures, right?

A. I said they're gross revenue figures, yes.

Q. So those don't actually have any relation to what you actually received in payments.

A. They're, I think, a common industry standard with respect to identifying what is activity. Because to do otherwise you would have to pay all sorts of different rates and you couldn't evaluate what relative percentage of business or service is being provided to a particular payer. You do it on a net basis.

THE COURT: Gross revenue is not actually revenue?

THE WITNESS: Gross revenue is, if you will, a statistic. Gross revenue isn't actual revenue unless we collect the full amount, which I think one point is that we don't collect the full amount and on very rare occasions. But in terms of -- without getting into a large explanation of it, I think we have to have a common basis in which we're billing out at -- what we accept as payment will vary based on the payer source.

So Medicaid will tell us what they're going to pay us. Medicare will tell us what they're going to pay us. But we negotiate with others against a -- if you will, when you're buying a car there's a sticker price and --

THE COURT: Sure, but most people think of revenue as income.

THE WITNESS: Well, in terms of GAAP, the way a CFO thinks about it, would not be actually -- net revenue would be --

THE COURT: So when you say gross revenue, you're talking about what, the cost of all of the services provided?

THE WITNESS: The gross billings associated -- so, for example, if somebody had an appendectomy, it would be the gross charge that would appear.

THE COURT: The charge?

THE WITNESS: The gross charge.

THE COURT: The highest soup cost.

THE WITNESS: Right.

THE COURT: But not who paid what for it.

THE WITNESS: Correct.

THE COURT: So it really represents what you would say is the charges they would like to

charge and collect for all of the services that we provide.

THE WITNESS: An oversimplification, yes.

THE COURT: You've got to deal with that.

THE WITNESS: Yes.

THE COURT: So it's not income.

THE WITNESS: It's not income, no.

THE COURT: Do you have a number that reflects what you actually took in?

THE WITNESS: Well, in terms of the net payments on Medicaid, it would be the 7.9 million for physician services, hospital services, and in and outpatient hospital services. So that would be net revenue to us, if you will.

And then you would subtract expenses from that to figure out what your -- what it cost to figure out your profitability.

THE COURT: From?

THE WITNESS: From any source.

THE COURT: No, but subtract what from what?

THE WITNESS: Well, if we're talking about Medicaid, as an example --

THE COURT: I'm just having trouble trying to figure out, did you do well or didn't you do

well?

THE WITNESS: We did poorly. Very poorly.

THE COURT: We would have charged $43 million if we -- I mean, that's what we charged, $43 million for the services we provided. We collected 7 million. That's not too good.

THE WITNESS: No. It's not very good at all.

THE COURT: Now, of that 43.3 I assume, from what you said earlier, that's some number under GAAP.

THE WITNESS: Yes.

THE COURT: And it reflects what? Actual cost plus a margin?

THE WITNESS: No. Well, the pricing reflects what we -- taking into account discounts and what we ultimately get paid, how high we have to set the rates, given that some people will pay us nothing. Some people will pay us, you know, 10 percent. Some people will pay us 90 percent.

THE COURT: To me that sounds like it really costs us 43.3 million in charges minus some amount, and we really have to cover that number.

THE WITNESS: My recollection for Medicaid costs was that that 7.9 million, when you take

into account what we were being paid before, was approximately 19 million in costs associated with that 43 million, leaving us with like a $9 million hit and then --

THE COURT: In other words, charge 43.3, our value of the services we provided that we should be charging you for, but we know we're not going to collect that kind of money.

THE WITNESS: Correct.

THE COURT: But it really cost us 9 million. We have to collect that amount of money.

THE WITNESS: We actually --

THE COURT: Or 19 million. I'm sorry.

THE WITNESS: 19 million.

THE COURT: 19 million. It really did cost us that. We have to collect that, and we only got 7.

THE WITNESS: Correct.

THE COURT: Okay.

Q. Allow me to just cover that, Mr. Lipman. The 19 million figure that you've thrown out as being your true cost, that's based on a Medicare cost formula, correct?

A. It is for the hospital inpatient, the

hospital outpatient, based on the Medicare cost report. As you know, there are certain services -- like if you're familiar with the cost report, like laboratory services which don't flow through that and physician services which don't flow through that. So there are other estimates to develop those costs.

Q. But what you are claiming as your true cost is based on a formula set by Medicare?

A. Predominantly, yes, if we're following what Medicare defines as a full cost.

THE COURT: These are the services we provided. This is what Medicare says we can charge for that to Medicare.

THE WITNESS: No. We would say Medicare has defined using -- it would be what Medicare says. Based on what you've spent, this is what the cost would be.

I think we're conflating two issues here. One is a Medicare standard with respect to what's an efficient and economical provider versus what we actually experienced.

THE COURT: What you actually experienced, yeah. All right.

Q. So the Medicare allowable cost doesn't

really answer the question of whether you could perform those same services more economically, does it?

A. Well, I would say that the answer to that question is that that's never been evaluated. Our contention is that the process of going through a proper amendment would be that that would have to be evaluated, and the adequacy of rates prior -- as I understand the Medicare standard, it's that rates are supposed to be set for the efficient and economical providers.

So this concept of absorbing losses is I'm not sure the standard that we're supposed to be evaluated against. I think it's the standard against an efficient and economical provider. At least that's in part. And the adequacy of rates at any given point in time -- I mean, if you look at the rates prior to these cuts, you know, there's a lot that's changed in the world that would make a rate that was adequate at one point in time totally inadequate given the meltdown in our economy we've had since 2008.

Q. In the Medicare allowable costs you get to include, you know, if you made capital expansions, new equipment, if you want to offer new services.

Are all of those things factored into how much money you spend to determine your allowable costs?

A. Here again I think that the costs -- capital costs are in that, but we don't -- New Hampshire does not have a standard as to what is an acceptable level of expenditure.

We would contend that what we've spent is in the efficient and economical category, but we haven't had a chance to make that case.

Q. And Medicaid is not the only source of what you've identified as being this total huge number of uncompensated care that you weren't paid for, is it?

A. Correct.

Q. And that includes all of your charity care to the uninsured, correct?

A. Correct.

Q. And you also claim on your 990 that you were losing money providing services on Medicare; isn't that correct?

A. That's correct, but a much lower number.

Q. Is that also included in your uncompensated care?

A. No. Medicare is not in that.

Q. And so prior to the recent budget session

in 2011 -- or let me just ask you that in a different way.

So what you're really complaining about here is that with the changes in the 2011 budget regarding not receiving DSH or UPL payments that is what has broken the camel's back -- the straw that broke the camel's back, correct?

A. That is correct, but I think the adequacy of rates in prior periods given the changes in the economy and the changes in our economic condition are a real issue that we've never really had a chance to put input on.

Q. You could have -- you weren't complaining before the recent budget session.

A. We have complained in the public policy arena for a long time. We are a community, in particular, that has a more challenging socio-demographic population than the state at large by a good factor.

Q. And you testified earlier that the New Hampshire Hospital Association does speak on your behalf, correct?

A. They do.

Q. And in regards to -- take a look at Exhibit 154. That's back in the white notebooks.

Before we talk about that specific document, I have some foundational questions.

You testified about outpatient and inpatient reductions at fiscal committee meeting in November of 2008. Do you recall that testimony?

A. I do.

Q. Now, were you aware that those were only effective for the rest of that biennium?

A. I would like you to repeat your question.

Q. Were you aware that the actions taken by fiscal were only effective for the rest of that state biennium, and that if those rates -- let me just add a little bit more -- and that if those rates were going to be carried forward something else had to happen?

A. I would say that with respect to the fact they were carried forward I am not aware that there was an opportunity to participate in a process that follows Medicaid statutes with respect to commenting on future years.

Q. And so if those rates were part of the 2010 and 11 budget that started in early 2009, if those, the rates being carried forward, were part of that, you weren't aware that you have an

opportunity to comment for the budget cycle?

A. Well, I think -- as your Honor, the honorable judge, had said earlier, I think there's a distinction between the budget process and what we're coming forward with with respect to what's required under the Medicaid statute. And in none of those processes did we get to have an opportunity to look at before and after type of rates and methodology adjustments, how it would affect us as an economical or efficient provider, how did that rate compare to that. We never got a chance to talk about specific beneficiary implications of that. We never got a context of how that rate going into future years would affect access given changes in the economy and other things affecting us.

I mean, I think, you know, to say that the budget process was a lot in the open, we're not arguing that point. We're arguing the point with respect to what's required under the Medicaid Act, that that wasn't followed, and it still hasn't been.

Q. If you could just go to page 3 of the exhibit that I just showed you, which is testimony -- which appears to be House division

finance testimony on page 3, testimony by Leslie Melby. Does that appear to be correct?

A. That is labeled House Finance Committee testimony on March 17, 2009.

Q. And page 3 is testimony by Leslie Melby, correct?

A. Correct.

Q. Do you know who Leslie Melby is?

A. I do.

Q. Who is he?

A. Leslie is the Vice President of State Affairs, I believe is her title -- of State Governmental Affairs.

Q. And when she appeared on March 17, 2009, at the first paragraph, who did she say she was there representing?

A. I guess, to be directly responsive to your question, she was representing the acute care hospitals of the state.

Q. And you're one of those.

A. We are.

Q. And so she was there representing you?

A. In the budget process. It's distinct from the Medicaid regulatory requirement process.

Q. And in the second paragraph she indicates

that the budget was carrying forward the November 2008 rate changes, correct?

A. I'm sorry. Which page are you on?

Q. That's still on page 3.

A. And what paragraph again, please?

Q. I believe it's the second paragraph down.

A. She's relating in that paragraph trends that are occurring between '99 and 2006, if that's what you're referring to.

Q. And in about the middle of that paragraph she indicates that HB-1 freezes current provider reimbursement rates, which means the 2009 cuts will be carried forward into the next biennium, correct?

A. I don't see that on the page you're referring to.

Q. It's in about the middle of the paragraph.

A. That's on page 2.

Q. Oh, I'm sorry.

A. I think. If it's the paragraph you're -- you've got that up on the screen. The paragraph I'm reading here talks about 15 years of -- the rate hasn't been updated for 15 years. That's not what I think you're referring to.

Q. No. It's the paragraph --

MS. SMITH: If I could approach, your Honor?

THE COURT: Anytime, Attorney Smith.

Q. It's at the bottom of the page. If you could go back to the first page of her testimony and about the middle of this paragraph.

A. Okay.

Q. Where it says HB-1 freezes?

A. Yeah. I see that.

Q. Okay. So I read that correctly?

A. Yes, you have.

Q. And then she goes on to talk about the negative impact on the hospitals, doesn't she?

A. She does. But in respect to the standard and being able to do the facility and geographic specific aspect, that's not in there, and I don't think it would completely satisfy the Medicaid regulations.

Q. And going forward, if you would look at Exhibit 156. This appears to be testimony to the senate finance committee in February of 2009 regarding the uncompensated care funds and the MET tax, correct?

A. Yes.

Q. And that's submitted by Mr. Ahnen from the

hospital association, correct?

A. Yes.

Q. And he was there representing the state's 32 acute care hospitals, right?

A. That's what it says here. It says community and specialty action.

Q. So there's some more facilities included in the hospital association other than just acute care hospitals, correct?

A. There's two rehab hospitals, to my understanding, and one psychiatric hospital.

Q. So before the budget was passed he was there providing testimony on behalf of the hospitals about the proposed changes to DSH and MET, correct?

A. Yes.

Q. And if you look at Exhibit 158, this is dated April 21, 2011, and again, this appears to be written testimony by the hospital association submitted to the legislature during the budget process. Is that a fair characterization?

A. It's a fair characterization, yes.

Q. And they were there representing, again, the state's 32 acute care community and specialty hospitals, correct?

A. Correct.
Q. And one of those is LRGH?
A. Correct.
MS. SMITH: I have just a few more questions comparing his more recent declaration to his original declaration, but it might be more than a minute or two.
THE COURT: Well, why don't you go ahead.
MS. SMITH: Pardon?
THE COURT: Go ahead.
Q. Do you have all three of your declarations there in front of you?
A. I do not. I have Exhibit 76, which I believe is the initial one.
Q. Your most recent one is Exhibit 78, that's that one, and your second one is here, and I believe you have the first one.
A. Correct.
Q. And in the table that you have -- in Exhibit 78 in table 5 you indicate that the cumulative total of what you are claiming as the impact of the rate reductions is $19,000,768, correct?
A. That's correct. Because we're excluding upper payment limit as compared to the earlier

testimony, yes.

Q. Okay. And that was a figure -- and going back to your first declaration, which I believe is this one, which is 76?

A. Yes.

Q. And in table 5 of Exhibit 76 you had initially claimed that your cumulative loss was $33,670,000, correct?

A. That's what's there, yes.

Q. And the only change you say between your third declaration and your first declaration is that the upper payment limit has been taken out of your 2010; is that correct?

A. Not exactly.

Q. Or 2011. Excuse me.

A. That's one factor. The other one is that this is specific to Lakes Region General Hospital.

Q. So table 5 is just Lakes Region General Hospital; whereas table 5 in your initial declaration included outpatient and physician? Is that what you're saying?

A. Let me restate that. It's inpatient, outpatient and physician for Lakes Region General Hospital.

Q. If you could clarify for me which one

you're talking about?
A. The most -- the one in 78 with the ID.
Q. 78?
A. 78.
Q. Is all of them?
A. 78 is the Lakes Region General Hospital physician, inpatient and outpatient hospital.
Q. That's all of them?
A. That's all of them.
Q. And the original was just Lakes Region?
A. No. That is LRG Healthcare, which is Lakes Region, Franklin and Alton.
Q. And Franklin is a critical care hospital -- is a critical access hospital that's not a plaintiff in this lawsuit, correct?
A. It is correct that Franklin Hospital is not here. We're one corporation though.
Q. And the rates that you complained about about the 2008 inpatient and outpatient reductions have not been applied to Franklin, correct?
A. The radiology was. The cost report settlement was.
Q. But can you answer my question? The inpatient and outpatient rate reductions were not applied to Franklin, correct?

A. That's correct.
Q. And Franklin has received a DSH payment this year, correct?
A. It has.
Q. How much money did Franklin receive?
MR. O'CONNELL: Objection, your Honor.
THE COURT: Sustained.
Q. But it has received a DSH payment?
A. It has.
Q. So LRGH has received a DSH payment because of Franklin?
MR. O'CONNELL: Objection.
THE COURT: I guess it has. It's one corporation.
MR. O'CONNELL: Withdrawn. I didn't hear her say LRG Healthcare.
MS. SMITH: I don't believe I have any further questions.
THE COURT: Any redirect, Mr. O'Connell?
MR. O'CONNELL: Briefly, your Honor. Two questions.

REDIRECT EXAMINATION

BY MR. O'CONNELL:
Q. Mr. Lipman, you were asked about the 3,000 patients that were notified.

A. Yes.
Q. Those were historic patients over approximately a three-year window, correct?
A. Yes.
Q. Have you tried to figure out on a going forward basis the number of Medicaid patients that will not be seen who would otherwise come to the practice?
A. We did make an estimate in my affidavit.
Q. What is your estimate?
A. I would have to reference it.
Q. Please do.
A. That based on the state's analysis of what they see as the use rates in the report that we looked at earlier, which is Plaintiff's Exhibit 50, applying the factors there, that ultimately we would expect in our service area 6,731 patients to access physician services.
Q. That would not have that opportunity?
A. That may not have that opportunity, correct.
MR. O'CONNELL: Thank you. Nothing further, your Honor.
THE COURT: All right. Thank you. Anything else?

MS. SMITH: No recross.

THE COURT: Mr. Lipman, you may step down. You're excused. I appreciate it.

Just by way of going forward, I understand you want to put on evidence of the 30(a) claims, and I understand the state probably does, as well, but I gather it's going to be somewhat cumulative, right?

MR. O'CONNELL: Yes, your Honor.

THE COURT: So maybe we can just hit the highlights of the 30(a) substantive requirements.

MR. O'CONNELL: Your Honor, may I ask -- when you say 30(a), are you speaking about only the procedural side of it or the substantive impacts?

THE COURT: Both.

MR. O'CONNELL: We will hit the highlights. We will hit the specific numbers. We will not be redundant with numbers. You will not see --

THE COURT: Great, great. And of course, as I've probably made clear at the last hearing, I'm particularly interested in the 13(A) issues. That's what I'm really particularly interested in.

I really doubt that I'm going to jump the

Supreme Court's claim on the 30(a) issues. I've been looking into it and I've been thinking about it quite a bit, and there's precedent in the First Circuit that basically says that's not a great thing to do when there's a case pending in the Supreme Court that's been submitted on briefs, been fully argued, and is pending resolution. So I doubt that's going to happen.

Well, I'll give you the chance to argue it. I'm just trying to be candid so we can fashion the presentation of the hearing. Because obviously at this rate you're going to take a week, not two days.

MR. O'CONNELL: We're still going to try to be done by the middle of tomorrow.

THE COURT: And I'm trying to help you.

MR. O'CONNELL: Yeah, I know you are, your Honor.

On the 30(a) issues, though, there is a procedural one, and that's before the Supreme Court. And I understand your analysis to us on that posture, but the substantive issue is not before the Supreme Court.

THE COURT: No, I understand. But you're not even going to get there -- if the procedural

issue fails, right, you're not going to get there?

MR. O'CONNELL: That's not true, actually. At end of the day -- they may comply with the procedural requirements, but at the end of the day they are substantive impact issues.

THE COURT: I guess I don't deem the procedural issue as, did you even have standing to be in here complaining about 30(a) issues. If the answer from the Supreme Court is, no, you don't, that's the end of that.

MR. O'CONNELL: I understand. Yes, your Honor. I understand. Thank you.

THE COURT: But I understand your desire to put on a merits record just in case. I mean, they may come out next week and say you certainly do. Who knows.

But by way of streamlining it -- to the extent you're going to hit the same points, I gather -- we don't need to go through all of the background of, you know, where did you go to school and where do you live and all of that.

MR. O'CONNELL: I will not. What time does the Court intend to proceed to today?

THE COURT: I usually go to 4:30, quarter of 5:00, unless that's a problem with any of you

or with any of your witnesses.

MS. SMITH: We had understood, I think, that we had three days this week.

THE COURT: You did?

MS. SMITH: Yes.

THE COURT: I have two days on my calendar.

MR. O'CONNELL: Yeah, we were noticed for three.

THE COURT: Noticed by whom?

MR. O'CONNELL: Actually, didn't we find out we have three days on the calendar?

THE COURT: Today is Tuesday. Isn't it two days? We have it for two. It's on the docket as two. Other than my patience, it's not critical. I think Thursday -- what do we have?

THE CLERK: I think you're available Thursday.

THE COURT: I think Thursday is sort of okay.

MR. O'CONNELL: That would explain the disconnect, your Honor. We were planning for three, both sides.

MS. SMITH: Right. I was just hearing two days, and I just wanted to clarify that we had

notice that it was Tuesday, Wednesday and Thursday this week.

THE COURT: Well, you understood differently from what I understood. My docket is marked out for two days, and I thought that was a little much, frankly. I mean it's -- you know, it's an evidentiary hearing on preliminary injunctive relief. We're not going to try the merits of the case. It's very likely to succeed. What's the deal? I can't imagine that you need three days.

I understand everybody has been designated and probably wants to have their ten minutes, but the facts aren't really that disputed, are they?

MS. SMITH: I think the adequacy of the notice is very much disputed and the access issue is --

THE COURT: Sure. That's just a matter of putting people up there on the stand to say, what notice did you give, what form did it take, how was it disseminated, who did it, who received it, that sort of thing, as opposed to $106,000 for lobbying on your tax return, let's kind of define what that might have been for. We don't need that. Not to be highly critical of you, Nancy,

but we need to be moving along.

THE CLERK: Thursday is not a good day.

THE COURT: It's not a good day?

THE CLERK: You're available Friday, but Thursday you have sentencings and tons of stuff.

THE COURT: Well, let's see how we do. I mean, I think if you get together -- I imagine a lot of this is the same testimony with just different numbers, right?

MR. O'CONNELL: Correct, your Honor.

THE COURT: Okay. Again, what I'm really interested in is any factual disputes that are material regarding the notice requirement for the 13(A) issues. If there's any evidence on that, that's what I really want to hear. I don't want to miss that, so flag that for me.

The 30(a), likely to be deferred until the Supreme Court decides the procedural posture. I understand you still want to build a record, but if we can try to do it in an efficient and effective way, that would be good. All right. See you at 1:30.

(LUNCH RECESS)

C E R T I F I C A T E

I, Susan M. Bateman, do hereby certify that the foregoing transcript is a true and accurate transcription of the within proceedings, to the best of my knowledge, skill, ability and belief.

Submitted: 1-23-1

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